Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an Inspection against the *National Standards for Safer Better Healthcare*.

Name of healthcare service provider:	Midland Regional Hospital Portlaoise
Centre ID:	OSV-0001075
Address of healthcare service:	Block Rd Ballyroan Portlaoise Co. Laois R32RW61
Type of Inspection:	Announced
Date of Inspection:	14/10/2025 to 15/10/2025
Inspection ID:	NS_0169

About the healthcare service

Model of hospital and profile

Midland Regional Hospital Portlaoise is a model 3 public acute hospital managed by the Dublin Midlands Health Region on behalf of the HSE at the time of inspection. Services provided by the hospital include:

- 24-hour emergency department service
- general surgery
- obstetrics and gynaecology
- general medicine
- paediatric services
- outpatient services
- transitional care.

The hospital serves a population within the counties of Laois, Kildare, Carlow, Offaly and North Tipperary.

The following information outlines some additional data on the hospital.

Number of beds	139 inpatient beds 19 day case beds

How we inspect

Under the Health Act 2007, Section 8(1)(c) confers the Health Information and Quality Authority (HIQA) with statutory responsibility for monitoring the quality and safety of healthcare among other functions. This inspection was carried out to assess compliance with the *National Standards for Safer Better Healthcare Version 2 2024* (National Standards) as part HIQA's role to set and monitor standards in relation to the quality and safety of healthcare.

To prepare for this inspection, the inspectors* reviewed information which included previous inspection findings (where available), information submitted by the provider, unsolicited information and other publicly available information since last inspection.

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*Inspector refers to an authorised person appointed by HIQA under the Health Act 2007 for the purpose in this case of monitoring compliance with HIQA's National Standards for Safer Better Healthcare.

During the inspection, inspectors:

- spoke with people who used the healthcare service to ascertain their experiences of receiving care and treatment
- spoke with staff and management to find out how they planned, delivered and monitored the service provided to people who received care and treatment in the hospital
- observed care being delivered, interactions with people who used the service and other activities to see if it reflected what people told inspectors during the inspection
- reviewed documents to see if appropriate records were kept and that they reflected practice observed and what people told inspectors during the inspection and information received after the inspection.

About the inspection report

A summary of the findings and a description of how the service performed in relation to compliance with the national standards monitored during this inspection are presented in the following sections under the two dimensions of *Capacity and Capability* and *Quality and Safety*. Findings are based on information provided to inspectors before, during and following the inspection.

1. Capacity and capability of the service

This section describes HIQA's evaluation of how effective the governance, leadership and management arrangements are in supporting and ensuring that a good quality and safe service is being sustainably provided in the hospital. It outlines whether there is appropriate oversight and assurance arrangements in place and how people who work in the service are managed and supported to ensure high-quality and safe delivery of care.

2. Quality and safety of the service

This section describes the experiences, care and support people using the service receive on a day-to-day basis. It is a check on whether the service is a good quality and caring one that is both person-centred and safe. It also includes information about the environment where people receive care.

A full list of the national standards assessed as part of this inspection and the resulting compliance judgments are set out in Appendix 1 of this report.

The inspection was carried out during the following times:

Date	Times of Inspection	Lead Inspector(s)	Support Inspector(s)
14/10/2025	08:50 – 17:25	Maeve McGarry	Eileen O'Toole Yvonne Young
15/10/2025	08:45 – 15:45	Maeve McGarry	Eileen O'Toole Yvonne Young

Information about this inspection

This inspection focused on nine national standards from five of the eight themes[†] of the *National Standards for Safer Better Healthcare*. The inspection focused in particular, on four key areas of known harm, these being:

- infection prevention and control
- medication safety
- the deteriorating patient[‡] (including sepsis)[§]
- transitions of care.[**]

The inspection team visited three clinical areas:

- Emergency department and the acute medical and surgical assessment unit (AMSAU)
- Emo Court Ward (medical ward)
- Paediatric Ward (paediatric ward).

During this inspection, the inspection team spoke with representatives of the hospital's Senior Management Team, Quality and Risk, Human Resources and Clinical Staff.

Acknowledgements

HIQA would like to acknowledge the cooperation of the management team and staff who facilitated and contributed to this inspection. In addition, HIQA would also like to thank people using the healthcare service who spoke with inspectors about their experience of receiving care and treatment in the service.

What people who use the service told inspectors and what inspectors observed

During the inspection, inspectors spoke with a number of patients, about their experience at Midland Regional Hospital Portlaoise. Patients were complimentary about the care they received and the staff, describing their experience staff as "*10 out of 10 for all of them*". A parent of a paediatric patient noted the effort made by staff to communicate with their child saying, *"staff make him laugh".* In the emergency department a patient described staff as "*amazing- could not do enough*".

[†] HIQA has presented the National Standards for Safer Better Healthcare under eight themes of capacity and capability and quality and safety.
[‡] Using Early Warning Systems in clinical practice improve recognition and response to signs of patient deterioration.
[§] Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency.
[**] Transitions of Care include internal transfers, external transfers, patient discharge, shift and interdepartmental handover.

Inspectors observed staff interacting with patients in a kind and respectful way, making sure patients and parents of paediatric patients were comfortable and their privacy was respected. Some of the patients who spoke with inspectors said they understood their plan of care and others were complimentary about the quality of food, with one patient saying it was "*excellent*" and "*fresh*".

While some patients knew how to make a complaint if needed, others were not aware about the process but said they would feel comfortable speaking to a staff member if they had any concerns.

Capacity and Capability Dimension

This section describes the themes and standards relevant to the dimension of capacity and capability. It outlines standards related to the leadership, governance and management of healthcare services and how effective they are in ensuring that a high-quality and safe service is being provided. It also includes the standards related to workforce and use of resources.

Midland Regional Hospital Portlaoise was found to be compliant with national standard 5.5, substantially compliant with national standard 5.8 and partially compliant with national standards 5.2 and 6.1 assessed under this dimension. Key inspection findings informing judgments on compliance with these four national standards are described in the following sections.

Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.

Inspectors noted that the hospital had established clear corporate and clinical governance structures, with defined roles and responsibilities to support the delivery of safe, high-quality care. Since HIQA's last inspection in 2024, the hospital is now part of the Dublin and Midlands Health Region, aligned with the HSE regional configuration. The hospital's interim hospital manager reported to the regional executive officer (REO) via an integrated healthcare area (IHA) manager. These governance arrangements, as described to inspectors, aligned with the hospital's organisational charts. Monthly performance meetings were held with the IHA manager, which included key metrics such as finance, human resources, quality and patient safety indicators, operational performance of scheduled and unscheduled care, and capital developments.

The senior management team (SMT) was responsible for leading performance and ensuring safe, effective services at the hospital. Meeting minutes submitted to HIQA indicated that the SMT met weekly, as per up-to-date terms of reference and key patient safety issues were addressed, though actions were not always clearly defined or time bound. Membership of the SMT included the clinical director, interim director of nursing, director of midwifery and a quality, risk and patient safety manager, each of whom oversaw their respective areas and reported directly to the interim hospital manager. On the day of the inspection, the hospital was managed by the interim hospital manager and several senior management roles were filled on an interim or temporary basis due to retirements and secondments, including the hospital manager, director of nursing, and quality, risk and patient safety manager. Furthermore, although there were plans to appoint a permanent hospital manager supported by two operations managers, one individual was covering all three of these roles on the day of inspection. This arrangement was not sustainable in the medium to long term, and the stability of the hospital's senior management team needs to be addressed to support consistent formalised governance arrangements.

A positive development since HIQA's 2024 inspection was the re-instatement of the hospital's governing quality function which was the Quality and Safety Executive Committee (QSEC). In addition, a quality, risk and patient safety manager was now in place. The re-establishment and resourcing of this function was a key part of the hospital's compliance plan following the previous inspection. This committee met in December 2024 and convened twice in 2025. While the re-established QSEC was operational at the time of the inspection, the governance structure for its subcommittees was not fully embedded in practice as the committee structure described to inspectors did not fully align with the organograms provided. In practice, not all hospital committees reported to the QSEC and some reported directly to the SMT. The governance and oversight arrangements for hospital committees and functions should be streamlined and more clearly delineated to ensure clear oversight.

As per the HIQA's previous inspection, the hospital had committees in place to oversee the hospital's performance in relation to the four areas of harm; a Healthcare Associated Infection (HCAI) Committee, a Drugs and Therapeutics Committee (DTC), an Unscheduled Care Committee, a Scheduled Care Committee and a Deteriorating Patient Committee. There was evidence of updates to QSEC from HCAI, DTC via pharmacy department and periodic updates relating to the deteriorating patient.

The hospital's HCAI Committee was chaired by the consultant microbiologist. There was evidence that this committee reported to QSEC, as per the terms of reference and updates included training, surveillance and audit outcomes.

Similarly to findings of the previous inspection, the Unscheduled Care Committee was not meeting every six weeks, as per the terms of reference. Also, the terms of reference were out of date. These indicated that the committee provided monthly reports to the senior management team (SMT) and reported to QSEC, although documented evidence of this was limited. However, oversight of hospital activity was demonstrated through monthly performance meetings with the IHA manager, which included both unscheduled and scheduled care. While hospital activity data was collated and monitored, the reporting arrangements did not fully align with the structure outlined in the terms of reference.

At regional level, the Dublin Midlands Health Region had a Healthcare Associated Infections (HCAI) and Antimicrobial Resistance (AMR) Regional Oversight Committee. This committee was attended by hospital's hospital manager, consultant microbiologist and reviewed relevant data across the region's acute services. Sepsis management was also included, for example, implementation of the updated national clinical guideline and the associated timeline for implementing this into clinical practice.

There was evidence of clinical leadership within the emergency department, with clinical oversight provided by an emergency medicine consultant who served as the lead consultant. Senior clinical decision makers[††] at registrar level were available on site in the emergency department 24 hours per day, seven days per week. In addition, each shift was supported by a designated nursing shift leader.

Overall, some progress has been made since the last inspection, particularly with the re-establishment of the hospital's overarching quality and patient safety function. The structures and reporting arrangements to the HSE Dublin and Midlands Health Region's IHA manager were in place. However, there were gaps in the formalised governance arrangements due to:

- Vacancies in the senior management team and key roles filled on an interim or temporary basis, which had the potential to impact the stability and sustainability of the management team.
- The documented reporting structure of some committees did not fully align with reporting structures in practice, which should be clarified to further formalise governance arrangements.
- The Unscheduled Care Committee, which was not meeting as per the terms of reference.

Judgment: Partially Compliant

[††] A doctor at registrar grade or a consultant who have undergone appropriate training to make independent decisions around patient admission and discharge.

Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.

The hospital had effective management arrangements in place to support and promote the delivery of safe and reliable healthcare services.

Governance of medication safety at the hospital was provided through the Drugs and Therapeutics Committee (DTC) which was chaired by the clinical director. The committee's scope included medication safety and there was a subcommittee for venous thromboembolism. Medication safety and the hospital's pharmacy service were led by the chief pharmacist, supported by a medication safety programme which outlined governance structures, medication management data, and short and long term objectives. The pharmacy department provided periodic updates to QSEC, including risks, work plans and horizon scanning. In addition, updates on medication related incidents and trends were periodically shared with the quality, risk, and patient safety manager. A documented pharmacy department work plan was in place for each quarter of 2025.

The hospital had a multidisciplinary Infection Prevention and Control (IPC) team and an annual plan for IPC for 2025. This plan set out objectives for the year focusing on reducing healthcare-associated infections, education and quality initiatives. However, it was unclear if this report had been finalised or formally approved. The IPC nursing team had an annual report for 2024. This report included compliance with HSE e-learning, quarterly care bundle validation reports, Carbapenemase-Producing Enterobacterales (CPE) screening compliance audits, information on hospital-acquired infections per case, hand hygiene results and required action plans for wards not reaching the 75% compliance threshold. This report was nursing developed and focused, and could be broadened to reflect inputs from the wider IPC team.

The hospital had an antimicrobial stewardship (AMS) programme, which had progressed since the previous inspection. Furthermore, the hospital now had a consultant microbiologist on site, compared to the previous remote arrangement. AMS rounds were now being carried out by the consultant microbiologist and the AMS pharmacist.

The hospital had an overarching Deteriorating Patient Committee (DPC) with two subcommittees for paediatrics and maternity. These committees met quarterly. The DPC was chaired by the clinical director and oversaw Early Warning Systems [‡‡] and

[‡‡] Early Warning Scores have been developed to facilitate early detection of deterioration by categorising a patient's severity of illness and prompting nursing staff to request a medical review at specific trigger points utilising a structured communication tool while following a definitive escalation plan.

sepsis management and had an annual audit plan. The Early Warning Systems in use at the hospital were; the Irish National Early Warning System (INEWS), the Irish Maternity Early Warning System (IMEWS), the Irish Paediatric Early Warning System (PEWS) and the Emergency Medicine Early Warning System (EMEWS) which had been implemented since the time of the previous inspection. Named clinical leads were in place for each Early Warning System used at the hospital, including separate consultants for IMEWS in general and maternity services. The DPC reported to QSEC and an example of a presentation on data from Q2 2025 included sepsis management. Minutes of the DPC were reviewed by inspectors had actions outlined and assigned to responsible persons. Minutes of the subcommittee for paediatrics submitted to HIQA indicated that the committee had oversight of audit activities related to the PEWS and staff education and training.

The hospital had management arrangements in place to monitor hospital activity, demand for urgent and emergency care and patient flow. The operational management of patient flow is discussed in more detail under national standard 3.1. Hospital activity was managed through daily meetings, including daily multidisciplinary board rounds and handover meetings. The hospital had developed a system to use electronic whiteboards to provide real-time visibility of bed capacity on screens and tablets to support patient flow. The hospital's Unscheduled Care Committee was chaired by the director of nursing and monitored hospital activity, surge capacity, compliance with national targets for patient experience times (PETs) and delayed transfers of care (DTOC). At the time of inspection, the average length of stay (ALOS) at the hospital was relatively low and within the HSE's targets. However, management reported that they had reduced access to convalescence beds in nursing homes and were limited to 11 beds in the off site transitional care unit. The hospital's frailty team was being developed at the time of the previous inspection and was not yet fully resourced.

The hospital had an approved escalation plan to address demand for urgent and emergency care. The hospital was not in escalation at the time of the inspection. Staff outlined actions for managing escalation including accommodating surge capacity within the AMSAU and the day ward. An extension to the emergency department was due to open in the months following the inspection, and this was to include a new paediatric emergency department and a respiratory assessment unit. This development will expand the overall footprint of the emergency department and increase the number of isolation rooms available, but inspectors were informed that from a capacity perspective, the new facility will only provide space for one additional trolley beyond the current ED capacity.

Overall, the hospital had management arrangements in place to support and promote the delivery of high quality, safe, and reliable healthcare services. These arrangements were strengthened by the re-instatement of the hospital's Quality and

Safety Executive function.

Judgment: Compliant

Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.

The hospital had systematic monitoring arrangements in place to identify and act on opportunities to continually improve the quality, safety and reliability of healthcare services. Performance data was reviewed regularly during performance meetings between the hospital and the IHA manager and through the Quality, Safety and Executive Committee (QSEC). Key risks escalated to the Dublin Midlands Health Region were in relation to staffing levels and recruitment across the quality and patient safety team, speech and language therapy, and maternity services.

The interim hospital manager had oversight of the hospital's risk management processes and was responsible for the hospital's corporate risk register. Inspectors found that while the hospital had risk management structures in place, it was unclear when the corporate risk register was last formally updated. Inspectors found that local risk registers at ward level were generally well maintained. Clinical nurse managers were responsible for managing risks within their clinical areas, implementing corrective measures and escalating high rated risks to the corporate risk register. Pharmacy and the infection prevention and control (IPC) teams also maintained their own risk registers. At the time of the previous inspection, the local risk policy was out of date and during this inspection, inspectors were provided with HSE risk management policies rather than a hospital specific policy.

The hospital had systems in place to identify and manage patient safety incidents through a local Serious Incident Management Team (SIMT) and the senior management team (SMT). The SIMT ensured that all serious reportable events and incidents were recorded on the National Incident Management System (NIMS)[§§] and managed in accordance with the Health Service Executive's Incident Management Framework. At regional level, a Serious Incident Management Forum (SIMF) for maternity-related incidents supported shared learning across the region. In addition, a meeting of quality and patient safety managers was held at regional level which included shared learning from incidents.

As per findings of the previous inspection, inspectors found a lack of oversight of

[§§] The National Incident Management System (NIMS) is a risk management system that enables hospitals to report incidents in accordance with their statutory reporting obligation to the State Claims Agency (Section 11 of the National Treasury Management Agency (Amendment) Act, 2000).

complaints management in line with national requirements. This is discussed further under national standard 1.8. Inspectors were informed the lack of progress was due to changes in quality and patient safety team resourcing.

Inspectors observed a proactive approach to audit, with evidence provided of audit across the four areas of harm, including environmental audits, infection prevention and control screening, care bundles, medication safety monitored through nursing care metrics, hand hygiene, transitions of care, and the deteriorating patient. Audits for the deteriorating patient were conducted more frequently than national policy based on local findings, demonstrating a proactive approach. The Healthcare Associated Infection Committee actively monitored infection prevention and control practices, and environmental audits which included equipment completed by household staff. The hospital monitored and reported data on antimicrobial consumption. Inspectors reviewed examples of INEWS escalation and response audits with an associated quality improvement plan, demonstrating a structured and proactive approach to monitoring and quality improvement. However, despite significant levels of audit activity, the hospital did not yet have an overarching audit plan. While there was a retrospective list of clinical audits carried out from 2022 to 2025 evident through QSEC presentations, oversight of audit activity could be improved with a prospective audit plan.

Overall, the hospital had systematic monitoring arrangements in place to support continuous improvement in the quality, safety, and reliability of healthcare services. There was some opportunity to improve the effective oversight, governance and management of complaints and audit activity.

Judgment: Substantially Compliant

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.

Hospital management had systems in place to plan, organise, and manage the workforce, supported by a Human Resource Operational Strategy (2023–2026). Workforce planning was a standing item at monthly performance meetings with the IHA manager. At the time of the inspection the total whole-time equivalent (WTE) workforce at the hospital's general services was 298 with 31 permanent and 29 temporary vacancies. In maternity services, the total workforce was 66, with 22 permanent and 19 temporary vacancies. Despite the human resources strategy in place, many of the key risks on the hospital's risk register were in relation to staffing. National workforce strategies had resulted in the loss of some posts contributing to service gaps in some areas. In speech and language therapy and occupational

therapy, some management and heads of services posts were lost and while the hospital continued to provide these services, the seniority of the team was reduced. Inspectors were informed that there were challenges due to delays in progressing posts due to recruitment processes and prioritisation of posts involving suppression of certain roles to accommodate others.

Documentation reviewed by inspectors showed that hospital management escalated 27 priority posts for immediate replacement to the REO. These posts included the hospital manager, a catering manager and assistant director of nursing for surgical services. Some of these were progressing through the recruitment process and some were pending approval.

There was some progress in relation to staffing within the senior management team since the last inspection with a quality, risk, and patient safety manager now in post. However, as discussed under national standard 5.2, at the time of inspection, several senior management roles were being filled on an interim or temporary basis and this was due to retirements and secondments. While there were plans to appoint a permanent hospital manager and two operations managers, there was only one person covering all three of these posts at the time of inspection.

Safer nursing staffing levels in line with the *Framework for Safe Nurse Staffing and Skill Mix*[***] were in place across the hospital, and an agency staff conversion initiative was underway, with approximately 20 eligible posts. Additional positive developments included the approval of a new 0.5 whole-time equivalent (WTE) neurologist post and a staffing uplift for the new emergency department facility.

The emergency department (ED) was approved for 16 WTE non-consultant hospital doctors (NCHDs) who provided 24/7 medical cover. As part of the new ED facility, staffing had been significantly uplifted with 36.5 additional posts approved, including a paediatric emergency medicine consultant, additional NCHDs and nursing staff. This represents a positive development for the department. However, there was no change in the number of consultant posts in the adult ED since the previous two HIQA inspections. The department was staffed with three consultants, one permanent staff member who was the clinical lead, and two locum consultants. The two locum consultants were clinically accountable and reported to the ED's clinical lead. As highlighted in previous reports, these three consultants covered a one in three, 24/7 on-call rota for the emergency department. The hospital has a relatively high ratio of ED attendances to consultants, and trends indicated that overall attendances were increasing. While the ED performance data indicated that the service was well managed, the long term sustainability of this staffing arrangement should be considered.

[***] [***] Framework for Safe Nurse Staffing and Skill Mix

The emergency department had an approved complement of 44.85 WTE nursing staff, with 39.28 positions filled at the time of inspection. On the first day of the inspection, all vacancies in the nursing roster were filled by agency staff. In the preceding week, rosters indicated that there were two gaps unfilled, with other gaps filled with agency staff or staff overtime. Nursing staff were supported by eight WTE healthcare assistants.

Medical paediatric patients were cared for in the paediatric ED which was located on the upper floor to the adult ED. Surgical paediatric patients were triaged and cared for in adult ED. Nurses in the adult emergency department were not paediatric trained, but inspectors were informed that there was a close, but informal working relationship between the two EDs. The lack of qualified paediatric nurses in the adult ED was on the local ED risk register. In the paediatric ward, 67% of staff nurses had a paediatric qualification and in the paediatric emergency department, approximately 83% of staff nurses had a paediatric qualification.

Overall, the pharmacy team were operating with a 70% staffing deficit, which impacted the provision of clinical pharmacy services across all areas in the hospital. A pharmacy technician visited the paediatric ward twice per week for stock control but the hospital did not have a paediatric pharmacist. The hospital did not have a medication safety pharmacist and lost the medication management CNM2 post to national recruitment strategies.

Staff had ready access to infection prevention and control nurses and could consult a microbiologist for expert advice. Since the last inspection, the hospital now had access to an onsite consultant microbiologist to provide clinical support, which was a positive development.

There were a number of risks identified by the hospital on the corporate risk register related to maternity staffing levels and these were escalated to the IHA manager. Inspectors were informed of recruitment challenges, reliance on agency staff and documentation indicated ultrasound services were outsourced.

Inspectors were informed that the total number of posts in the quality and patient safety function had reduced due to national recruitment strategies which impacted on the allocation of resourcing for managing complaints. The impact of this are discussed under national standard 1.8. Resources should be prioritised to ensure effective management of complaints and patient feedback in line with national standards.

As per findings of the previous inspection, the hospital did not have a formal system in place to manage mandatory training. Nursing training records were maintained using Excel spreadsheets, which inspectors were informed were difficult to maintain. In some cases, training was completed but certificates were not submitted, and

therefore documentation was incomplete. The hospital lacked oversight of non-consultant hospital doctors (NCHDs) training, which was recorded on the National Employment Record (NER) system.

Records indicated varying levels of staff attendance at and uptake of mandatory and essential training across departments. On Emo Court Ward, 81% of nurses had completed standard and transmission based precautions and hand hygiene training, while 62% had completed donning and doffing personal protective equipment and 90% were trained in INEWS. Compliance was lower in the ED, where records indicated 52% of nurses completed training on standard and transmission based precautions and 52% for hand hygiene, while records indicated that 50% of healthcare assistants in ED completed standard based precautions and 24% had completed hand hygiene training. Paediatric nurses demonstrated higher attendance, with 85% trained in standard and transmission based precautions and 92% in hand hygiene. Among paediatric ward staff, 61.9% of doctors had completed advanced paediatric life support training and 64% of nurses had paediatric life support training, while 100% of paediatric nurses had paediatric life support training. While some in-house medication training was provided at induction, mandatory training records indicated that for example, 64% of paediatric ward nurses had completed HSE-land medication training.

The hospital had a relatively high level of absenteeism which was 8.8% in August 2025, above the HSE's target absenteeism rate of ≤4%. Inspectors were informed that much of this was attributed to maternity related leave and long term sick leave. Inspectors were informed that the SMT monitor absenteeism and it is managed under a managing attendance policy.

Overall, there were some positive developments since the previous inspection with the appointment of a microbiologist onsite, a quality, risk, and patient safety manager and approval of additional posts for the new ED facility. Hospital management demonstrated planning and organisation to support safe, high-quality care. However, challenges with recruiting and sustaining the workforce continued including:

- Staffing shortfalls and reliance on agency staff and overtime in some clinical areas, and gaps within the senior management team.
- There was no increase in ED medical consultants since the last inspection, and consultants continued to operate a one in three on-call rota, the sustainability of which should be considered.
- Pharmacy staffing deficits continued to impact the provision of the clinical pharmacy service.
- There was a lack of oversight of mandatory training, with no system in place to monitor records and attendance was low from staff in some clinical areas.

- Changes in staff resourcing of the hospital's quality and patient safety function impacted complaint management and patient feedback processes.

Overall, staffing challenges continued to pose a risk to the hospital's ability to consistently deliver safe, high-quality care across all services.

Judgment: Partially Compliant

Quality and Safety Dimension

This section discusses the themes and standards relevant to the dimension of quality and safety. It outlines standards related to the care and support provided to people who use the service and if this care and support is safe, effective and person centred.

Midland Regional Hospital Portlaoise was found to be substantially compliant with three national standards (1.6, 3.1 and 3.3) and partially compliant with two national standards (1.8 and 2.7). Key inspection findings leading to these judgments are described in the following sections.

Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.

Patients' privacy and dignity in the emergency department was generally supported, particularly for those accommodated in individual cubicles and single rooms. Staff made efforts to maintain patient dignity but the physical environment presented challenges to consistently maintaining patient dignity and confidentiality. Inspectors observed that some patients were accommodated on chairs in a corridor within the emergency department, which was also noted during previous inspections. These patients did not have access to call bells. While staff made efforts to preserve dignity, such as moving patients to cubicles for examination and one patient noted that they were provided a trolley to sleep in overnight, the setting compromised privacy and confidentiality.

Staff promoted a person-centred approach to care and were observed by inspectors to communicate respectfully with patients, in ways that promoted their dignity and privacy. In the paediatric ward the use of privacy curtains was seen to be used for breast feeding mothers and there were privacy considerations for adolescent patients. Staff were observed knocking before entering single rooms. Patients' autonomy and independence were supported, for example, patients reported being kept informed and updated about their care plans, with one patient telling an

inspector, *"I know what's happening."* Inspectors noted the availability of patient information leaflets in clinical ward areas, which provided details about medical conditions and HSE services.

In the paediatric ward, staff were observed being sensitive to individual needs of patients and their parents. Parents encouraged to stay with children. Parents and children who spoke with inspectors were aware of how to access assistance and one parent commented that staff had *"gone above and beyond."* A dedicated child sensory room was available and toys were provided for children to play with. Parents gave positive feedback about being accommodated to stay overnight and were provided with meals. One parent shared that they were encouraged to write down their questions while waiting, so they would have them ready when speaking with the medical team which was a practical approach to supporting communication.

For the most part, patient confidentiality was maintained during the inspection. Healthcare records were appropriately stored in locked trolleys, and personal information was handled securely in the clinical areas visited. Inspectors observed one instance where patient information was briefly visible on a screen in a clinical area, however, this screen was designed to time out automatically.

Overall, staff promoted a person-centred approach to care, however, the physical environment did not always support patient's dignity, privacy and autonomy.

Judgment: Substantially Compliant

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.

The hospital had systems and processes in place to respond to complaints and concerns. At the time of inspection, the quality, risk and patient safety manager acted as the designated complaints officer and was responsible for managing complaints and implementing recommendations from reviews of complaints. Oversight of complaint handling and response times was provided by the hospital's Quality and Safety Executive Committee (QSEC). However, there was a lack of oversight and monitoring of the timeliness of responses and the management of complaints by the relevant governance structures.

Complaints were managed in accordance with the HSE's *'Your Service Your Say'* management policy and information about this process was displayed in the clinical areas. Patients who spoke with inspectors were not aware of the complaints procedure but stated they would speak with a nurse if they had a complaint to make.

Staff aimed to resolve complaints at the point of care in line with national guidance. Staff informed inspectors that unresolved complaints were escalated to clinical nurse managers. Inspectors were informed that verbal complaints were documented in patient's medical records but were not recorded in a way that allowed tracking or trend analysis, representing a missed opportunity for shared learning and quality improvement. Inspectors also found that learning from complaints in clinical areas was not routinely analysed or disseminated to staff working in those areas, which also highlighted a missed opportunity for learning and service improvement.

The numbers of complaints received via *'Your Service Your Say'*, email and telephone call to the hospital were presented at quarterly QSEC meetings. The complaints were trended as clinical complaints, or 'Your Service Your Say' which referred to non-clinical complaints. The themes of complaints received were outlined in QSEC reports and included; access, waiting times, dignity and respect, and communication and information. However, these themes were not analysed or trended, making it difficult to identify which complaints were most prevalent.

In 2024, the hospital received 146 complaints and 806 compliments. Minutes from QSEC meetings indicated that there were delays in progressing complaints from 2024 and that these were being worked through in 2025. In 2025, up to the end of September, 164 complaints were received. There was some lack of clarity on the proportion of complaints responded to within timelines recommended in guidelines, but inspectors were informed that 27% of complaints received in August 2025 and 21% of complaints received in July 2025 were resolved within the recommended 30-day timeframe, significantly lower than the HSE's 75% target.

Inspectors were informed that changes in the staffing resources allocated to the quality and patient safety team impacted the timely management of complaints. The quality, risk and patient safety manager was now in post, which represented an improvement in resources from the previous inspection. However, the former consumer affairs manager post, whose remit included complaints management, was vacant since August 2023 and was not identified to be replaced. While changes to staffing levels are noted, further efforts are needed to manage resources to ensure complaints are managed in an appropriate timeline and consistently in line with national targets.

There was no evidence of quality improvement initiatives implemented on foot of complaints received. Some staff who spoke with inspectors in the clinical areas were not aware of the national inpatient experience survey results. Paediatric patients are not included in the national inpatient experience survey currently, and the hospital did not have an alternative method to survey paediatric patients other than feedback forms available in the paediatric waiting area.

Inspectors observed information on independent advocacy services displayed in the some of the clinical areas visited.

Overall, HIQA was not satisfied that the systems and processes in place were fully effective in resolving complaints and concerns promptly and effectively, and there was no notable improvement in complaint management since the previous inspection. While the hospital received a considerable number of compliments from patients, several opportunities to enhance services based on patient feedback continued to be missed. Changes in the resource allocation for managing complaints are noted but further efforts are needed to manage resources in a way that prioritises effective complaint management in order to comply with national standards.

Judgment: Partially Compliant

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.

The hospital was generally clean and well maintained with some signs of wear and tear evident. Inspectors observed that the hospital's physical environment remained largely unchanged since the previous inspection. Challenges with adequate storage facilities continued from the previous inspection. Equipment was stored on corridors in all the clinical areas visited and there were boxes on floor in storage areas which did not facilitate cleaning. Inspectors visited Dunamaise ward which was 33-bedded ward visited at the time of the previous inspection, and as per previous findings, spacing of beds in multiple-occupancy rooms and toilet facilities were inadequate.

In clinical areas visited, wall-mounted alcohol-based hand sanitiser dispensers were strategically located and readily available for staff and visitors. Hand hygiene signage was clearly displayed in the clinical areas. A programme of sink upgrades was underway and hand hygiene sinks in the clinical areas visited met the required specifications[†††] with some exceptions, for example, the hand hygiene sinks in two of the sluice rooms visited by inspectors.

A system was in place to identify equipment which had been cleaned using green tags and this system was seen to be in use. Equipment was cleaned by healthcare assistants. The cleaning supervisors had oversight of the cleaning schedules in the clinical ward areas visited. Nursing staff indicated that they were satisfied with the

[†††] Department of Health, United Kingdom. *Health Building Note 00-10 Part C: Sanitary Assemblies*. United Kingdom: Department of Health. 2013. Available online from: https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_00-10_Part_C_Final.pdf

levels of cleaning on ward and the responsiveness to maintenance requests. The ward areas visited had a dedicated cleaner Monday to Sunday, 8 to 8 with night staff allocated to cover cleaning requirements out of hours.

There was evidence of appropriate placement of patients requiring isolation due to communicable infectious diseases or to protect those vulnerable to infection, despite the limited availability of single isolation rooms. Patients requiring isolation were observed to be accommodated in single rooms with appropriate signage, and doors were observed to be closed in line with national guidance. Personal protective equipment (PPE) was readily available to staff.

During the inspection, national policies were provided to inspectors in terms of infection prevention and control (IPC) management. There was oversight of patient placement by the Infection Prevention and Control Team. While inspectors were informed that a national guideline was in operational use to guide prioritisation of patients for single-room isolation, a local policy to support prioritisation of placement of patients requiring isolation was due to be updated as per the compliance plan, but the updated policy was not provided to inspectors.

Inspectors visited the paediatric ward and found it to be clean, well maintained, and the facilities were considerate of the needs of the patient cohort. All patient rooms were ensuite, with toilet and shower facilities, and one room was specially fitted out as a sensory room. A patient requiring isolation was accommodated in a single room, with appropriate signage in place to guide the use of standard and transmission based precautions. The ward also featured a kitchen and tea room for parents, an indoor playroom, and a secure outdoor area for children. However, some issues were noted, including the storage of beds along corridors and boxes placed on the floor in the storage room, which impeded effective cleaning.

An extension to the current emergency department (ED) was under construction at the time of the inspection and was almost complete. Inspectors were informed that this new area would accommodated the paediatric emergency department and the respiratory assessment unit, expanding the footprint of the ED and the number of isolation rooms available. In the existing ED, ambulatory patients were accommodated on chairs on a narrow corridor. There were limited toilet and shower facilities in the ED and this was noted on the department risk register. The ED had a dementia bay, sensory bay and a room on the upper floor for end-of-life care, if required.

As noted in the findings of the previous inspection, some cleaning equipment was found not to be stored in accordance with national guidance, presenting a risk of contamination. Inspectors observed that sluice rooms in both the emergency department (ED) and the Acute Medical and Surgical Assessment Unit (AMSAU) were

being used to store cleaning equipment such as mops and mop buckets due to insufficient dedicated storage facilities. The previous inspection identified that a flat mop system was not used in line with nationally recommended practice. Inspectors were informed that following the previous inspection, a business case had been developed and a new system was costed. However, implementation had not been pursued due to the cost of purchasing the system and the cost necessary to retrofitting of storage areas to accommodate it.

Inspectors noted in two of the clinical areas visited some chemicals were stored in storage rooms in units which were not locked. This was brought to the attention of clinical nurse managers in those areas and was rectified on the day of inspection.

Overall, there was a lack of significant progress on the previous inspection findings with many of the same environmental challenges persisting. Infrastructural issues included;

- inadequate storage facilities
- bed spacing in some multi-occupancy rooms
- lack of toilet and shower facilities in some clinical areas
- lack of isolation rooms.

These infrastructural issues remain unresolved and improvement requires longer-term planning. Capital infrastructure investment is underway with plans for additional inpatient bed capacity plus support services coming 2027-2030 and a new emergency department facility nearing completion. Notwithstanding the infrastructural deficits, there were opportunities for improvement in the short-term including:

- ensuring there is an up-to-date local policy available to guide prioritisation of patient placement
- suitable storage of cleaning equipment and upgrade of the mop system in use.

Judgment: Partially Compliant

Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services

The interim hospital manager had responsibility for oversight of the corporate risk register. Inspectors found evidence that risks were escalated from the senior management team to the Dublin Midlands Health Region through performance meetings. The corporate risk register was reviewed by inspectors. There was a lack of evidence that the register was maintained and kept up to date as some risks had been closed out operationally but remained open on the register, and it was unclear

when the register was last formally updated. Local risk registers on wards and in the emergency department were found to be up to date with assigned responsible persons and controls in place. Staff had access to electronic copies of policies procedures and guidelines in clinical areas.

The infection prevention and control team maintained a local risk register identifying key infection risks, including the lack of isolation rooms, limited toilet facilities in some areas and inadequate bed spacing on Dunamaise Ward. Since the previous inspection, progress had been made in promoting hand hygiene, with the development of hand hygiene champions across the hospital, including both nursing staff and healthcare assistants.

Surveillance testing for carbapenem-resistant enterobacteriaceae (CRE) was carried out on admission in line with national guidelines. Local adaptations were in place for high-risk patient groups, such as those from nearby congregated living settings, who were routinely screened on admission. The response measures taken following a previous vancomycin-resistant enterococci (VRE) outbreak were reviewed. Despite regular antimicrobial stewardship (AMS) ward rounds involving an AMS pharmacist and a consultant microbiologist, the hospital recorded high levels of antimicrobial consumption, exceeding national key performance indicators in 2024. Inspectors were informed that this was primarily due to meropenem usage, attributed to the ageing patient cohort. Inspectors were advised that no significant improvement was expected in 2025 data, but there were no substantive plans or defined targets in place to improve compliance with antimicrobial stewardship KPIs.

Deficits in the pharmacy service due to reduced WTE, as discussed under national standard 6.1, was on the hospital's risk register. The hospital did not have a medication safety pharmacist and no longer had a medication management CNM2. Staffing levels in pharmacy impacted on availability to provide a full clinical pharmacy service. Certain clinical areas were prioritised such as Emo Court ward and patients transferring to the off site transitional care unit. While there was no dedicated clinical pharmacy service for paediatrics, complex cases were reviewed on an individual basis. Medication reconciliation was carried out using a risk-based approach, supported by a system that used incident data to identify high-risk medications, and patients prescribed these medications were prioritised for medication reconciliation.

Risk reduction strategies were in place for high-risk medications including sound-alike look-alike drugs (SALADs) lists and high-risk medication lists. Labels were used for anticoagulants and the hospital had defined processes for prioritising time-critical medicines. Medicines information was available via a smartphone based platform, in hardcopy format and the BNF for children was available on the paediatric ward. Doctors had access to a paediatric formulary and clinical guidelines to support paediatric prescribing via smartphones, while nurses in the adult ED did not have

access, and inspectors were informed there were plans to purchase a tablet to support access.

Medicines in the emergency department were observed to be stored in a temperature controlled medication refrigerator but there were no records of daily temperature checks. Inspectors reviewed records of temperature checks documented by pharmacy staffing during stocking, which was done three times per week. Inspectors were informed the temperature was visually checked by nursing staff daily but was not documented, and this was rectified at the time of inspection.

Early Warning Systems were in place across the hospital for all relevant patient groups. There were clinical leads assigned to the each of the Early Warning Systems and compliance with national KPIs were monitored. Inspectors reviewed a sample of INEWS, EMEWS and PEWS charts, which were found to be completed appropriately in line with policy. EMEWS was in use in the emergency department including the waiting area post-triage following a pilot. The local EMEWS policy reviewed by inspectors on the day of inspection was in draft format. Based on staff feedback, the hospital had decided to adapt the national chart locally by removing pre-hospital vital signs. As this adaptation falls outside national guidance, the hospital should ensure the practice is formally documented in policy and is subject to appropriate monitoring.

Inspectors reviewed the national SEPSIS clinical audit report from 2024 and the associated quality improvement plan. The hospital was preparing to implement the updated national sepsis guidance and form imminently following inspection. Staff in the clinical areas had good awareness of the upcoming change and preparations taking place.

The hospital had an emergency response team who responded to internal rapid response bleep calls. Inspectors observed this team responding to a call. Inspectors were informed that this this response was activated when a patient had an INEWS score of seven or above, or in other clinically indicated circumstances, and that response times were monitored.

The hospital had systems in place to monitor, analyse and respond to information relevant to the provision of high quality, safe services in the emergency department. The hospital tracked emergency department quality and safety metrics per HSE guidelines. On day one of inspection, the emergency department was functioning reasonably well, with 26 patients registered. All waiting times were in line with HSE Patient Experience Times (PETs) performance indicators but there were three admitted patients in the ED who exceeded the nine-hour KPI for discharge or ward admission. The average registration-to-triage time was nine minutes, within the national KPI and the range was up to 1 hour and 30 minutes. Triage times were

flagged on the ED risk register and staff attributed the issue to the availability of only one triage room. Another risk on the ED risk register was increasing attendances which had risen by 11% from 2023–2024 and although there was no increase year-to-date in 2025, attendances among patients aged 75 and older had increased.

The conversion rate for the emergency department was 21.5% to-date in 2025 at the time of inspection, which had decreased from 2024 levels by 1.6%. This compares favourably to other model 3 hospitals. The re-admission rate is 24% which is above the national KPI.

On day one of inspection, there were no surge patients in the Acute Medical and Surgical Assessment Unit (AMSAU). The AMSAU had a capacity of nine bays and one isolation room. As was noted in the previous inspection, the hospital's AMSAU was not functioning in line with the national model for assessment units. Access to the AMSAU was for patients who had completed the ED process. The AMSAU did not operate as an external pathway for general practitioners and there was no direct access from ED. The hospital did not have a short-stay unit to support the AMSAU service. From July to September, 2025, 213 patients were seen at the AMSAU, of which 36 (17%) were seen within 4 hours and 46 (22%) were seen between 4 and 6 hours. Hospital management and staff indicated that there was opportunity to improve patient flow but noted clinician resourcing was as a key constraint.

The AMSAU unit and the day ward were both used for surge capacity, depending on capacity requirements and staff described operational challenges in reconfiguring these two services to accommodate surge patients and prioritise surgical days cases. To minimise transitions of care, patients sometimes stayed in their current location while staff and function of the units adjusted. Inspectors spoke with agency staff nurses who primarily staffed overnight surge. Those who spoke with inspectors indicated they completed required mandatory training. Inspectors reviewed medical records of overnight surge patients and found that documentation including early warning scores were being completed in line with practice across other areas of the hospital.

Two multidisciplinary safety huddles, at 9am and 2pm were held in the emergency department to discuss the status of all patients in the department and identify patients that were of concern. Board rounds took place on wards and were attended by inspector. It was noted these discussions included discussion of the patients' INEWS scores and was multidisciplinary in attendance. Electronic whiteboards were used to guide patient flow. Inspectors reviewed a sample of discharge letters which indicated that they were prepared for general practitioners in a timely manner. The use of ISBAR stickers were observed in clinical areas. However, there was a lack of evidence that the most recent version ISBAR tool was in use at the hospital. A stroke bypass protocol was in place, developed by the Dublin Midlands Health Region in

collaboration with other hospitals in the area.

Overall, the hospital had arrangements in place to protect patients from the risk of harm. The hospital was performing well in terms of HSE patient experience times (PETs) but had identified opportunity to improve triage times. The AMSAU was not functioning in line with the national model for assessment units. There are some areas for improvement such as ensuring the corporate risk register in maintained, ensuring local policies are approved and current, and consistently applying nationally recommended tools and guidance.

Judgment: Substantially Compliant

Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.

The hospital had patient-safety incident management systems in place, with oversight on the day of the inspection provided by the interim hospital manager. Incidents were managed in line with the HSE's Incident Management Framework. Incidents were discussed at senior management team (SMT) and Quality, Safety and Clinical Effectiveness (QSEC) meetings. The trending of incidents was reported to the Dublin Midlands Health Region via monthly performance meetings.

There were systems were in place for the tracking and trending of patient-safety incidents. The number of incidents reported from the beginning of 2025 to the time of inspection were; 795 category 3 incidents, 210 category 2 incidents and 4 category 1 incidents. There were no serious reportable events reported by the hospital to the national incident management system in 2025 up to July. Analysis of incidents were provided to QSEC meetings and at performance meetings with the IHA manager. Medication safety incidents were categorised using the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) and were monitored by the Drugs and Therapeutics Committee. Incidents in relation to infection prevention and control were monitored by the IPCT and reported at HCAI committee meetings. The hospital was compliant with the national targets for the completion of concise and comprehensive reviews of patient safety incidents within 125 days of notification. Compliance with the 30-day KPI for reporting incidents to the National Incident Management System (NIMS) improved significantly, with the hospital meeting the national target in Q1 2025 and falling slightly below target at 69.9% in Q2 2025.

Staff who spoke with inspectors were knowledgeable about how to report an incident and inspectors saw evidence of incident reporting by staff in clinical areas visited, which was paper-based. While governance structures were in place, inspectors noted

opportunities to strengthen learning from incidents at ward level, as staff were often unaware of outcomes of incidents which had occurred.

There was evidence of incident learning to improve practice in the pharmacy service. Learning from incidents which had occurred informed the prioritisation of medication reconciliation. Also, incident learning informed updates to the medicines prescription and administration record, including updates to the direct oral anticoagulants section.

Overall, there were systems in place to effectively identify, manage and report patient safety incidents, while there was scope to enhance local learning from incidents and to work towards consistently meeting national targets for reporting incidents.

Judgment: Substantially Compliant

Conclusion

Capacity and Capability

Since the last inspection, the hospital had moved under the governance of the HSE Dublin and Midlands Health Region, with formalised arrangements in place to report on the hospital's performance. There was also some progress with the re-establishment of the hospital's quality and safety executive function, although further work is required to fully formalise the internal reporting structures of all of the hospital's committees. There were vacancies within the senior management team and many key posts were filled on an interim or temporary basis. The stability of the senior management team should be addressed to ensure effective governance and the efficient delivery of healthcare services.

The hospital's workforce was impacted by national workforce strategies, and there were challenges reported in recruiting staff to certain services and with the recruitment process itself. The hospital must continue to progress recruitment efforts including agency conversion where possible, and to monitor and prioritise key functions and services to ensure safe care for patients. Since the last inspection, no progress has been made in implementing a system for managing mandatory training and there was a lack of oversight of mandatory training records across many staff groups. Records indicate that staff attendance at and uptake of mandatory and essential training needs improvement.

Quality and Safety

Staff were observed delivering care with kindness, consideration, and respect. Staff were seen making efforts to uphold dignity, privacy and confidentiality. However, patients' privacy and dignity was compromised in areas where patients were

accommodated on corridors in the emergency department and in ward areas where beds were placed in close proximity.

Challenges with the environment persisted since the previous inspection including; inadequate storage, lack of isolation rooms, and in some clinical areas there was inadequate bed spacing and limited toilet and shower facilities. A new emergency department was due to open imminently following the inspection and further long term capital investment is planned for 2027–2030. In the short term improvements such as improving cleaning equipment storage should be prioritised.

The hospital had arrangements in place to protect patients from harm, with improvements noted since the previous inspection, with all relevant Early Warning Systems now in clinical use. While the hospital was compliant with most PET times on the day of inspection, the hospital had identified opportunity to improve triage times. A comprehensive clinical pharmacy service was not available in all clinical areas but there was a system for prioritisation of medication reconciliation based on incident learning. There was opportunity for hospital management to strengthen arrangements to protection patients from harm by ensuring the corporate risk register is kept up to date, key local policies are approved and current, and that nationally recommended tools and guidance are applied.

The hospital's systems and processes for managing complaints and concerns were not fully effective, and there had been no notable improvement since the previous inspection. Although the hospital received a considerable number of compliments from patients, opportunities to use feedback to enhance services were missed. Further efforts are required to prioritise resources effectively to ensure compliance with national standards and improve complaint management.

The hospital had systems in place to effectively identify, manage, and report patient safety incidents with progress made toward meeting national targets for incident reporting. There was opportunity to improve the sharing of learning from patient safety incidents with staff. There were examples of learning from incidents to enhance clinical practice in certain areas such as medication safety, however, this could be strengthened across all services.

Appendix 1 – Compliance classification and full list of standards considered under each dimension and theme and compliance judgment findings

Compliance Classifications
An assessment of compliance with selected national standards assessed during this inspection was made following a review of the evidence gathered prior to, during and after the onsite inspection. The judgments on compliance are included in this inspection report. The level of compliance with each national standard assessed is set out here and where a partial or non-compliance with the national standards is identified, a compliance plan was issued by HIQA to the service provider. In the compliance plan, management set out the action(s) taken or they plan to take in order for the healthcare service to come into compliance with the national standards judged to be partial or non-compliant. It is the healthcare service provider's responsibility to ensure that it implements the action(s) in the compliance plan within the set time frame(s). HIQA will continue to monitor the progress in implementing the action(s) set out in any compliance plan submitted. HIQA judges the service to be **compliant, substantially compliant, partially compliant** or **non-compliant** with the standards. These are defined as follows:

Compliant: A judgment of compliant means that on the basis of this inspection, the service is in compliance with the relevant national standard.
Substantially compliant: A judgment of substantially compliant means that on the basis of this inspection, the service met most of the requirements of the relevant national standard, but some action is required to be fully compliant.
Partially compliant: A judgment of partially compliant means that on the basis of this inspection, the service met some of the requirements of the relevant national standard while other requirements were not met. These deficiencies, while not currently presenting significant risks, may present moderate risks, which could lead to significant risks for people using the service over time if not addressed.
Non-compliant: A judgment of non-compliant means that this inspection of the service has identified one or more findings, which indicate that the relevant national standard has not been met, and that this deficiency is such that it represents a significant risk to people using the service.

Standard	Judgment
Dimension: Capacity and Capability	
Theme 5: Leadership, Governance and Management	
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare	Partially Compliant
Standard 5.5: Service providers have effective management arrangements to support and promote the delivery of high quality, safe and reliable healthcare services.	Compliant
Standard 5.8: Service providers have systematic monitoring arrangements for identifying and acting on opportunities to continually improve the quality, safety and reliability of healthcare services.	Substantially Compliant
Theme 6: Workforce	
Standard 6.1: Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare	Partially Compliant
Dimension: Quality and Safety	
Theme 1: Person-centred Care and Support	
Standard 1.6: Service users' dignity, privacy and autonomy are respected and promoted.	Substantially Compliant
Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant
Theme 2: Effective Care and Support	
Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

Theme 3: Safe Care and Support	
Standard 3.1: Service providers protect service users from the risk of harm associated with the design and delivery of healthcare services.	Substantially Compliant
Standard 3.3: Service providers effectively identify, manage, respond to and report on patient-safety incidents.	Substantially Compliant

Compliance Plan for Midland Regional Hospital Portlaoise

Inspection ID: NS_0169

Date of inspection: 14 and 15 October 2025

Compliance plan provider's response:

Standard	Judgment
Standard 5.2: Service providers have formalised governance arrangements for assuring the delivery of high quality, safe and reliable healthcare.	Partially Compliant

Outline how you are going to improve compliance with this national standard

Action 1: Develop and implement a workforce planning strategy to fill the key posts currently occupied on an interim basis to ensure the stability and sustainability impact of the senior management team.

- A recruitment campaign completed to appoint a Hospital Manager with a successful candidate appointed on 23/11/25.

- A recruitment campaign is currently underway to appoint a General Manager - Target date for completion 31/03/25.

- MRHP is currently engaging with HR to progress the permanent appointment fo the Director of Nursing and QRPS Manager posts within senior management once approval has been received at IHA level - Target date for completion 31/03/25.

Action 2: Audit review of all documented hospital committees reporting structure identified on the day of inspection that did not fully align with reporting structures in practice with the completion of an improvement plan to address identified gaps to further formalise governance arrangements - Target date for completion 31/03/26.

- Complete audit review of the hospital teams and committee structures to standardise governance structure and reporting lines - Target date for completion 31/03/26.

- Update areas where gaps identified to provide assurance all hospital committees report formally to QSEC - Target date for completion 31/03/26.

- Standardise committee reporting templates to include actions, owners, follow-up mechanism to track timelines for closure of actions - Target date for completion 31/03/26.

- Publish updated hospital's organogram with enhanced governance structures and reporting lines - Target date for completion 31/03/26.

Action 3. Audit review of the operation of the Unscheduled Care Committee supported by a service improvement plan to address identified gaps to ensure operations are in line with documented Terms of Reference - Target date for completion 31/03/26.

- Conduct an audit review to identify gaps in governance and reporting process of the Unscheduled Care Committee structures in line with Terms of Reference - Target date for completion 31/12/25.

- Update areas where gaps identified to provide reassurance all hospital committees report formally to QSEC - Target date for completion 31/12/25.

- Publish updated hospital's organogram with enhanced governance structures and reporting lines.

Action 4: Quality improvement plan to ensure appropriate Quality and Patient Safety governance oversight for compliance against relevant regulatory standards - Target date for completion 31/03/26.

- Introduce an Annual Assessment of Quality and Patient Safety against required standards for 2025 - Target date for completion 30/6/26.

- Develop and publish an Quality and Patient Safety Annual Review Report for 2025 - Target date for completion 31/03/26.

- Develop and implement a 2026 Quality & Patient Safety Programme for MRHP = Target date for completion 31/03/26.

Timescale:

30th June 2026

Standard 6.1 Service providers plan, organise and manage their workforce to achieve the service objectives for high quality, safe and reliable healthcare.	Partially Compliant

Outline how you are going to improve compliance with this national standard

Action 1: Develop Workforce Plan (2026-2027) to fill the key roles filled on an interim basis to enhance the stability and sustainability impact of the senior management team - Target date for completion 15/10/26.

- Scope out a long-term sustainable workforce plan for the recruitment of staff (WTE requirements, deficits, recruitment timelines, and succession planning) linked to patient safety. Key priority areas:

i. ED medical consultant staffing arrangements in line with growing attendance rates

ii. Pharmacy staffing to enhance clinical pharmacy provsiion

iii. Staff shortages generating a reliance on agency staff and overtime usage

iv. Posts filled on an interim basis to enhance the stability and sustainability impact of the senior management team

v. QPS staffing to ensure appropriate oversight and implementation of risk management, incident management and patient feedback management

- Submit monthly recruitment progress updates to SMT and IHA Management Team.

Action 2: Establish a Process to enhance governance oversight of mandatory training compliance - Target date for completion 31/03/26.

- Develop and implement a formalised system to provide data reporting on:

i. the level of staff attendance at training;

ii. confirmation training complete;

iii. evidence of certification;

iv. breakdown by individual departments, and oversight of NCHDs recorded on the National Employment Record (NER) training

- Assign responsibility for monitoring and escalation of low recording levels.

- Quarterly compliance reporting to support review at SMT and QSEC level.

Action 3: Establish a Process to Stabilise the Hospital's Quality & Patient Safety Healthcare services - Target date for completion 30/06/26.

- Business case for additional funding to address resource enhancements to the Consumer Affairs team in the QPS department.

-Review and generate a quality improvement plan to enhance the governance oversight of the hospital complaints and audit activity management processes in line with national requirements.

- Develop an overarching hospital audit plan to enhance governance oversight to manage the continuous improvements of the quality, safety and reliability of healthcare services.

Timescale:

15th October 2026

Standard 1.8: Service users' complaints and concerns are responded to promptly, openly and effectively with clear communication and support provided throughout this process.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

Action 1: Ensure a robust governance oversight and timely management of complaints - Target date for completion 31/03/26.

- Conduct an audit review to identify gaps in governance oversight for management and monitoring of complaint responses.

- Implement an escalation pathway for overdue responses through line management to reinforce shared accountability with managerial structures.

- Develop a business case for the recruiting of a Consumers Affairs Manager to meet national targets.

Action 2: Improve hospital learnings from complaints data – Target date for completion 30/06/26.

- Produce quarterly complaints trend report from compliants data for senior management review.

- Present 2025 annual complaints report to SMT and QSEC (Feb 2026).

- Disseminate trend-based learning across all hospital areas

Action 3: Improve patient-facing information and accessibility – Target date for completion 30/06/26.

- Implement a Quality improvement plan informed by patient feedback.

- Introduce a hospital-wide visual tools, i.e., "You Said We Did" to share actions.

- Provide refresher education to Paediatric staff on signposting parents/guardians feedback channels.

Action 4: Strengthen Staff Knowledge and accountability for Complaints Management - Target for completion 30/09/26.

- Publish periodic complaints performance dashboards.

- Share operational learning from complaints across all hospital departments.

- Deliver training on Complaints Management and the National Care Experience Programme for all staff.

- Issue a standard operating procedure for complaints management, outlining roles and responsibilities.

Timescale:

30th September 2026

Standard 2.7: Healthcare is provided in a physical environment which supports the delivery of high quality, safe, reliable care and protects the health and welfare of service users.	Partially Compliant

Outline how you are going to improve compliance with this national standard.

Action 1: Ensure consistent and safe patient placement practices – Target date for completion 31/12/25.

- Review and update hospital policy to guide prioritisation of patients requiring isolation.

- Communicate updated policy to all clinical and operational teams.

- Monitor compliance through periodic audits and feedback loops.

Action 2: Maintain safe and compliant storage and cleaning practices -– Target date for completion 31/12/25.

- Develop and implement a plan for monitoring chemical and cleaning equipment storage.

- Upgrade flat mop systems in line with national recommended practices. - Conduct quarterly checks to ensure adherence to safety standards. Action 3: Optimise hospital environment for safety and efficiency improvements - Target date for completion 31/12/25 and ongoing thereafter. - Prioritise corridor clutter removal and storage optimisation. - Implement standardised equipment storage and cleaning systems (tagging, designated locations). - Continue monthly environmental cleanliness audits with action trackers. - Maintain oversight through HCAI Committee and QSEC. Action 4: Improve Documentation and Governance of Physical Infrastructure Risks – Target date for completion 31/12/25 and ongoing review thereafter. - Capture all environmental risks on departmental risk registers; escalate strategic risks as needed. - Document mitigation actions and integrated findings into long-term hospital capital planning.
Timescale: 31st December 2025 with ongoing monitoring thereafter.